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Notice of Independent Review Decision

IRO REVIEWER REPORT
Date: X
IRO CASE #: X

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: X

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: X

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☐ Overturned (Disagree)

☒ Partially Overtuned (Agree in part/Disagree in part)

☐ Upheld (Agree)

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- X

PATIENT CLINICAL HISTORY [SUMMARY]: X who was injured on X. X sustained X. X from behind. X injuries included a X. Post-injury, X continued to experience functional impairment of the right eye, as the X. X reported persistent severe headaches, chronic neck pain, and right hip pain. The diagnosis was intractable chronic post-traumatic headache (X); cervicogenic headache (X); postconcussive

syndrome (X); and cognitive impairment (X9).

X was seen by X, MD via telemedicine on X for a follow-up of concussion / headache. The pain was rated X on the morning of the day of the visit. X had daily headache, which was described as experiencing everyday, constant and sometimes rated X. These persistent headaches continued to impact X daily life. X was X and was started on X as X was having difficulty with sleeping. X sleep had improved. X had not received several of X medications, which were helping X headache, including X. These medications were re-ordered. X was taking X. X continued to have great deal of fatigue. The headache was associated with X, but X nausea had improved with X. X continued to have difficulties with memory and forgot a great deal of things. X had ongoing irritation in X eyes, which did tend to worsen during activities such as taking showers. X continued to use X eye drops to manage the irritation. On examination, X was “alert and oriented to person, place, time and situation grossly, recent, remote, memory, and attention, and concentration in order to be intact.” Expressive and receptive speech modalities were intact. Mood and affect were appropriate for the situation and judgment and insight were fair. Expressive and receptive speech modalities were noted to be intact. X were ordered to assess X.

X underwent a Designated Doctor Examination (DDE) by X, MD, on X, for determining maximum medical improvement (MMI) and impairment rating (IR). Eye examination revealed a visual acuity of X in the right eye (OD) and X in the left eye (OS). Right eye X was noted. Range of motion of the bilateral wrists was as follows: X degrees of flexion and extension bilaterally; X degrees radial deviation bilaterally; and X degrees ulnar deviation bilaterally. Elbows revealed flexion X degrees bilaterally; extension X degrees bilaterally; and pronation and supination X0 degrees bilaterally. Shoulders revealed flexion X degrees bilaterally; extension X degrees bilaterally; abduction X degrees bilaterally; adduction X degrees bilaterally; and internal and external rotation X degrees bilaterally. Thigh girth was X on the right and X on the left. Calf girth was X bilaterally. Hip range of motion showed flexion X degrees on the right and X degrees on the left; extension X degrees on the right and X degrees on the left; abduction X degrees bilaterally; adduction X degrees bilaterally; and internal and external rotation X degrees bilaterally. Knees revealed flexion X degrees bilaterally; extension X degrees bilaterally. Cervical spine range of motion revealed flexion X degrees, extension X

degrees, right flexion X degrees, left flexion X degrees, right rotation X degrees, and left rotation X degrees. Triceps reflex was X on the right. Reflexes of X were noted in biceps bilaterally and in left triceps. Motor strength was X in bilateral biceps and bilateral triceps. The diagnoses were right upper eyelid laceration status post surgery resulting in lagophthalmos; cervical sprain; traumatic brain injury (TBI); depression and posttraumatic stress disorder (PTSD). Regarding MMI, Dr. X noted, X sustained X on X, during severe weather conditions. X injuries included a X. Post-injury, X continued to experience functional impairment of the right eye, as the X. X reported persistent severe headaches, chronic neck pain, and right hip pain. In addition to X physical injuries, X endorsed significant psychological symptoms consistent with X. X was receiving X. X efforts included active participation in X. X remained under the care of Dr. X (X) and Dr. X at X. X was referred to X to determine MMI and IR; however, X declined to be seen by X. Therefore, the MMI and IR was determined by history, physical exam and available medical records. Since X declined further evaluation, X would be placed at Clinical MMI on X. X reached clinical Maximum Medical Improvement on X. Further material recovery was no longer anticipated. Dr. X noted X qualified for a X. On X, X was evaluated by X, MD, via telemedicine for follow-up of concussion / headaches, and for medication refill. X returned for a chronic condition follow-up focused on X daily headaches. X described experiencing headaches every day, noting that they were constant and sometimes reached a severity of X to X out of X. These persistent headaches continued to impact X daily life. X was apparently taken off of X and started on X as X was having difficulty with sleeping. X sleep had improved. X knew that X had not received several of X medications that were helping with X headaches, including X. These medications were recently reordered. In addition to this, X was taking X. During the visit, Dr. X did advise X that X should be taking this medication X. X described that X continued to have a great deal of fatigue. The headaches were associated with X, but X nausea had improved with X. X was awaiting to have X. X also knew that X continued to have difficulties with memory and forgot a great deal of things. In addition to X headaches, X reported ongoing irritation in X eyes, which tended to worsen during activities such as taking showers. X mentioned that X continued to use X. Vitals revealed a blood pressure of 154/102 mmHg and BMI 27.62 kg/m2. On examination, X was noted to be alert and oriented to person, place, time and situation grossly, recent remote, memory, and attention, and concentration in order to be intact. Mood and affect were appropriate for the situation and

judgment and insight were fair. Expressive and receptive speech modalities were noted to be intact. The assessment was X. Medications were refilled. Referral was provided to the X. It was noted, “I am recommending X. To provide insights into potential areas of X. Long term goals to use the findings from the X. To improve cognitive performance and emotional regulation by targeting specific areas of X. This approach will help inform X. I am recommending a X. This evaluation will provide valuable insights into the impact of the accident on cognitive abilities and help inform the development of an appropriate treatment plan.

X underwent a X by X, MP, PhD indicating a X were recommended.

An X on X revealed X were noted. There were X.

Treatment to date included X.

Per an appeal letter dated X by X, MD, the requested X was medically necessary to objectively evaluate X persistent X.

Per a utilization review adverse determination letter dated X, the request for X was denied by X, DO. Rationale: “X. A clinical practice guideline for the X. ODG states that X. X that visual evoked potentials (X) are used in the field of X. X. X may be an inexpensive screening tool to evaluate isolated X. In this case, the claimant is over X months out from the reported date of injury. There is no documentation of clear rationale for performing the requested X. There is no evidence of X. Without submission of high-level evidence-based medicine research which would support that the results from this specific assessment are clinically meaningful and how these results will specifically impact the treatment plan and facilitate recovery, this request is not medically necessary.”

An appeal letter dated X, by X, MD, documented the following. The payer assertion was, “X.” Dr. X provided clinical rebuttal and required justification as follows, “While the patient reports subjective improvement in symptom severity (e.g., improved sleep on X), X has not been formally assessed. Symptomatic improvement does not equate to the cognitive recovery required for safety-sensitive duties, and relying on it for return-to-work decisions is clinically inappropriate and unsafe.” “The focus must shift from symptom improvement to

the functional deficits that persist. The patient continues to demonstrate significant functional deficits, including short-term memory loss, forgetfulness, difficulty concentrating, mental fog, and word-finding difficulties." "X is a X. 'Improvement' is an insufficient and dangerous metric for return-to-duty clearance. Objective demonstration of cognitive capacity for split-second decision-making, threat assessment, and reaction time is required. Public safety liability precludes a return to duty based on subjective reporting alone." "The patient has reached a plateau in symptomatic improvement at X months post-injury. The persistence of objective and functional deficits at this stage (e.g., daily headaches X, chronic memory issues, uncorrected visual deficits, and poor balance/gait) indicates that maximal benefit from X." The payer assertion was, "There is no documentation of clear rationale for performing the requested X." Dr. X provided clinical rebuttal and required justification as follows, "ODG guidelines provide principles for X; they do not, and cannot, endorse specific proprietary tools by name. The requested assessment is selected based on its clinical appropriateness for this case and its alignment with ODG's principles for X. The record demonstrates multiple objective deficits supporting this X: Neuropsychological testing showed a Neurological Deficit Score Rating of X (Mild to moderate impairment), severe impairment in delayed memory, and a Defective Storage Memory Profile. Visual/Functional: X has objective lX of the right upper eyelid, a resulting visual acuity of X, and Romberg X/unstable X. The X are necessary to assess the integrity of sensory processing pathways driving X dizziness." The Component-Based Guideline Justification is "The comprehensive battery is required because X symptoms are complex and multi-systemic." Regarding X, "ODG/ACOEM supports testing when symptoms persist > X weeks to quantify deficits and guide rehab." The objective deficits confirmed included severe impairment in delayed memory, executive function, and a Neurological Deficit Score of X. Regarding X, "ODG and clinical practice supports X. X assess integrity of visual pathways." The objective deficits confirmed included unstable X, dizziness, and decreased visual acuity (X). The X, was a "Functional test to assess X." It was "Necessary to assess underlying X. Regarding countering the "X Not Recommended" Argument, the payer assertion was, "The denial cites ODG's stance against routine X." Clinical rebuttal and required justification: "It is critical to distinguish the X in this context) of this assessment from a X. The X component, however, is not used to detect X; it is a functional test used to assess the X like attention and information processing speed." "This application of X is consistent

with X. Its indication is purely for X." Dr. X noted, "The failure to approve this test creates a significant safety hazard and interferes with the clinical integrity of the treatment plan. X inability to maintain attention for a full shift and X impaired executive function are critical risks for a X. The objective data from the X is the only definitive measure that can safely clear X for duty or mandate appropriate cognitive rehabilitation, thereby mitigating significant public safety and employer liability risks. The alternatives exhausted were as follows: "X. Escalation to objective, multi-modal diagnostics is the mandatory next step per the stepped-care model to prevent chronicity and guide the X." "We formally request the immediate reversal of the adverse determination. Based on the objective evidence provided, this X is not only medically necessary but is the only responsible course of action to ensure patient and public safety."

Per a reconsideration review adverse determination letter dated X, the appeal request for X was denied by X, MD. Rationale: "ODG states that X. ODG also notes that X, is not recommended for X. X, or X, is a modification of X using X. The relevance and clinical utility of X have been studied for numerous conditions; however, its use in clinical practice remains largely investigational. ODG states that X. A consensus statement recommends further multidisciplinary evaluation, including X. Medical literature from X note that X. X have a clinical application in X. Medical literature from X. X is not indicated for patients who can undergo traditional standard X. Medical literature by X. note that dysfunction of the X. Future studies should consider implementing more complex statistical methods to better account for these factors. In this case, the provider mentions clinical findings and significant subjective complaints from the documentation dated X. Also, indicated in the report that the claimant has X. As per progress report dated X, the physical examination shows that the claimant noted to be alert and oriented to person, place, time and situation grossly, recent remote, memory, and attention, and concentration are intact. The claimant's expressive and receptive speech modalities are also intact. The claimant's mood and affect are appropriate for the situation and judgment and insight are fair. There is no documentation of ongoing X. There is also no evidence of X. On the current report, the claimant complains of ongoing eye irritation and daily headaches with X. The provider states that the claimant has Xs and visual acuity of X. However, there is no documentation that the claimant has X. There is also no indication that the claimant X. The cited medical literature state that X is not indicated for patients

who can undergo X. In addition, the claimant has depression and there is no evidence-based guideline support for the use of X. The provider notes that X is requested to evaluate for X. This is performed as a distinct procedure to inform the overall clinical picture. The cited medical literature notes that future studies should consider for using X. Based on the submitted review of the documentation and recommendations from evidence-based guidelines, the request for X is not medically necessary."

An appeal letter dated X, by X, MD, documented the following. Despite X, X continued to exhibit debilitating symptoms X months post injury. The records documented cognitive dysfunction including short-term memory loss, forgetfulness, difficulty concentrating, mental fog and word-finding difficulties. The neurological symptoms included daily headache rated X, chronic dizziness / vertigo, balance problems, X. The clinical maximal improvement date of X was determined administratively by the Designated Doctor largely because X declined specific referrals at that time, not because functional recovery was complete. The statutory maximal medical improvement date extended to X. The recovery had plateaued under X. This functional plateau was the precise clinical indication for escalating to objective diagnostics to guide a X. Symptomatic improvement did not equate to the X. Neuropsychological testing had already documented a neurological deficit score of X indicating mild to moderate impairment and severe impairment in delayed memory. The X was necessary to monitor these specific deficits with granular data on reaction time and processing speed that standard tests did not capture dynamically. X had visual acuity of X for right eye, X. The requested X. The request included X. The claimant was X months post injury with persistent, life altering symptoms. The testing was for X. This application was consistent with X. The denial of X relied on a superficial review that ignored documented objective data and the critical safety requirements of X occupation. X could not safely return to X. The testing was the only evidence-based method to accurately determine if X was fit for duty or required specific, X.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

In this case, the provider mentions clinical findings and significant subjective complaints from the documentation dated X. Also, indicated in the report, the claimant has X. As per progress report dated X, the physical examination shows

that the claimant noted to be alert and oriented to person, place, time and situation grossly, recent remote, memory, and attention, and concentration are intact. The claimant's expressive and receptive speech modalities are also intact. The claimant's mood and affect are appropriate for the situation and judgment and insight are fair. There is also no evidence of X. On the current report, the claimant complains of ongoing eye irritation and daily headaches with X. The provider states that the claimant has X and visual acuity of X. However, there is no documentation that the claimant has X. There is also no indication that the claimant X. The cited medical literature state that X is not indicated for patients who can X. In addition, the claimant has depression and there is no evidence-based guideline support for the use of X for depression and its use in clinical practice remains largely investigational. The provider notes that X is requested to evaluate for X. This is performed as a distinct procedure to inform the overall clinical picture. The cited medical literature notes that future studies should consider for using X. Given the claimants continued impairment in delayed memory, executive function, neuropsychological testing would be medically necessary as it is clinically important to quantify and delineate the cognitive deficits.

Based on the submitted review of the documentation and recommendations from evidence-based guidelines, the request for X are not medically necessary. Based on the submitted review of the documentation and recommendations from evidence-based guidelines, the request for X is medically necessary.

Partially Overturned.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **AHRQ- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- ☒ **MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☐ **PRESLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**